



COUNTY OF LOS ANGELES
OFFICE OF THE COUNTY COUNSEL

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March 24, 2009

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ADOPTED

BOARD OF SUPERVISORS
COUNTY OF LOS ANGELES

TO: SACHI A. HAMAI
Executive Officer
Board of Supervisors

46

APRIL 7, 2009

Attention: Agenda Preparation

FROM: JOHN F. KRATTLI
Senior Assistant County Counsel

Sachi A. Hamai
SACHI A. HAMAI
EXECUTIVE OFFICER

RE: **April Key and Tyler Adkins v. County of Los Angeles**
Los Angeles Superior Court Case No. PC 040 966

Attached is the Agenda entry for the Los Angeles County Claims Board's recommendation regarding the above-referenced matter. Also attached are the Case Summary and the Summary Corrective Action Plan to be made available to the public.

It is requested that this recommendation, the Case Summary and the Summary Corrective Action Plan be placed on the Board of Supervisors' agenda.

JFK:rfm

Attachment

Board Agenda

MISCELLANEOUS COMMUNICATIONS

Los Angeles County Claims Board's recommendation: Authorize settlement of the matter entitled April Key and Tyler Adkins v. County of Los Angeles, Los Angeles Superior Court Case No. PC 040 966, in the amount of \$395,000, plus assumption of the Medi-Cal lien in the amount of \$213,196, and instruct the Auditor-Controller to draw a warrant to implement this settlement from the Department of Health Services' budget.

This medical negligence lawsuit by a patient and his mother arises from treatment received at Olive View Medical Center.

CASE SUMMARY

INFORMATION ON PROPOSED SETTLEMENT OF LITIGATION

CASE NAME	Tyler Adkins and April Key v. County of Los Angeles
CASE NUMBER	PC 040966
COURT	Los Angeles Superior Court North Valley District
DATE FILED	July 5, 2007
COUNTY DEPARTMENT	Department of Health Services
PROPOSED SETTLEMENT AMOUNT	\$395,000, plus assumption of the Medi-Cal lien in the amount of \$213,196.
ATTORNEY FOR PLAINTIFF	Peter McNulty, Esq.
COUNTY COUNSEL ATTORNEY	Narbeh Bagdasarian
NATURE OF CASE	<p>This is a medical malpractice case brought by April Key and her son, Tyler Adkins, related to the care and treatment they received at Olive View Medical Center ("OVMC").</p> <p>On June 23, 2006, April Key, who was pregnant, presented to OVMC labor and delivery clinic with increased blood pressure. To manage her blood pressure, the medical staff prescribed magnesium sulfate. Due to staff's error,</p>

the patient actually received Pitocin instead of magnesium sulfate.

The OVMC personnel immediately recognized the medication error and placed the patient on the correct medication. On June 27, 2006, April Key gave birth to Tyler Adkins.

Both Tyler Adkins and April Key brought a lawsuit against the County of Los Angeles, contending that OVMC failed to provide them with proper medical care.

Although the County asserts that the medication error did not cause any injuries to Tyler Adkins or April Key, the Department of Health Services agrees to the proposed settlement of this case in the amount of \$395,000 plus assumption of the Medi-Cal lien in the amount of \$213,196.

PAID ATTORNEY FEES, TO DATE	\$59,458
PAID COSTS, TO DATE	\$36,302.88

REVISED



Summary Corrective Action Plan

Date of incident/event:	June 24, 2006
Briefly provide a description of the incident/event:	On June 23, 2006, April Key, who was pregnant, presented to Olive View/UCLA Medical Center labor and delivery clinic with increased blood pressure. To manage her blood pressure, the medical staff prescribed magnesium sulfate. Due to staff error, April Key actually received Pitocin. The hospital personnel immediately recognized the medication error and placed April Key on the correct medication. On June 27, 2006, April Key gave birth to Tyler Adkins.

1. Briefly describe the root cause of the claim/lawsuit:

- Medication error causing emotional distress

2. Briefly describe recommended corrective actions:
(Include each corrective action, due date, responsible party, and any disciplinary actions if appropriate)

- Appropriate personnel corrective actions were done
- A system wide survey was done related to the administration of Pitocin and Magnesium Sulfate. All DHS hospitals have appropriate procedures to manage these medications.
- A system-wide policy for Magnesium Sulfate as a high alert medication for OB areas was implemented
- A national survey was done related to the administration of Pitocin. All DHS hospitals have practices and procedures that are consistent with national standards.
- Staff were inserviced on lab reports disclosure

3. State if the corrective actions are applicable to only your department or other County departments:
(If unsure, please contact the Chief Executive Office Risk Management Branch for assistance)

- ☐ Potentially has County-wide implications.
- ☐ Potentially has implications to other departments (i.e., all human services, all safety departments, or one or more other departments).
- X Does not appear to have County-wide or other department implications.

Signature: (Risk Management Coordinator) <i>K. McKenna</i>	Date: 3/21/09
Signature: (Interim Chief Medical Officer) <i>R. Splawn</i>	Date: 3/3/09
Signature: (Interim Director) <i>W. Chum</i>	Date: 3-4-09